DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/14/2023 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ONID NO. 0330-0331
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		435120	B. WING_		10/31/2023
	ROVIDER OR SUPPLIER	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST VIBORG, SD 57070	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)	
F 000	INITIAL COMMENTS		FO	000	
	compliance with 42 C requirements for Long conducted from 10/24 from 10/30/23 through Memorial Nursing Ho compliance with the frand F609. On 10/25/23 at 4:10 p was identified relating and persistent psychological provided at 2:15 p provided a plan for rejeopardy for F609. At	me was found not in ollowing requirements: F600 c.m., immediate jeopardy to alleged sexual abuse ological symptoms at F600, illeged violations at F609. ed the building at 4:30 p.m.			
F 600 SS=J	survey team reviewed documentation for rer jeopardies. Immediate a.m. The resident census of Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropriation and exploitation as desincludes but is not limited.	moval of the immediate by was removed at 11:30 was 43. Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This	F 6	The Administrator, Director of Nursing (I and interdisciplinary team in collaboratio the medical director to review, revise, cranecessary, policy and procedure for a thevent investigation, documentation, and reporting process to necessary authority regulation, regardless of resident family preference. On 10/26/2023 at 1:00 Director of Social Services spoke with resident 8. When a she feels safe and secure, resident resp with 'I think so'. When asked if she feels a welcoming and friendly environment here.	on with eate, as forough per key per
	ACC (COM)	SUPPLIER REPRESENTATIVE'S SIGNATURE	4	TITLE	(X6) DATE
1 ind	nou Hauger			'Administrator	11/22/2023

following the date of survey whether print a plan of correction is provided. days following the date these documents are made available to the facility. NOV 2 2 2023 program participation.

Facility ID: 0101

ish the institution may be excused from correcting providing it is determined that ns.) Except for nursing homes, the findings stated above are disclosable 90 days or nursing homes, the above findings and plans of correction are disclosable 14 februencies are cited, an approved plan of correction is requisite to continued Any deficiency statement ending with an asterisk C denetes a deficiency which other safeguards provide sufficient protection to the patients. (See instructions.)

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ '		CONSTRUCTION	(X3) DATE : COMPI	
		435120	B. WING			10/:	31/2023
	ROVIDER OR SUPPLIER MEMORIAL NURSING H	OME		3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH WASHINGTON ST /IBORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	\$483.12(a) The facilit §483.12(a) (1) Not use physical abuse, corpor involuntary seclusion This REQUIREMENT by: A. Based on observate review, and policy revensure one of one res necessary care to me after she made an all resident (28). Findings include: 1. Observation and in a.m. with resident 8 a nursing home reveale *She alleged that she and the perpetrator "e *There was a lacerati that she said she acc perpetrator being on leverage." *She was able to rem perpetrator's name a resident at the nursin -That resident was no facility. *She remembered sh about the incident, bu who she had told. *When the incident h her chair asleep. She	ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced witten, interview, record view, the provider failed to sident (8) had received the eet her psycho-social needs egation of sexual assault by exterview on 10/24/23 at 10:25 about her experience in the ed: e was raped at that facility did not complete." on on her left shin and foot puired from the alleged top of her trying to "get ember the alleged and said he was another	F	600	responded with yes. When asked if she have a loved one needing care like here likely would you be to recommend, and resident answered with 4 (on a scale of 5 being the highest). SS also reassess resident using the Trauma Screen on 10/26/2023. SS Director asked Resident would like to speak more to someone, like ounselor, about her experiences and hare affecting her and she said, 'no.' So Services Director clarified that she is cuseeing a counselor and resident had not recollection of the fact that she does cumeet with two counselors regularly and aware of this incident. Counselors have in their visit notes from 7/28/2023 and 7/31/2023. Resident continues with conservices. Referral sent to Sanford Psych Psychology for outpatient services. Rehas pertinent diagnosis of delusional dalzheimer's disease, Parkinson's disease depression. Resident 8 has had previo inpatient psychiatric stays at Avera Bel Health. SSD/designee will meet with reaction 2 x's/week for 4 weeks to allow resident concerns/feelings and to evaluate her psychosocial wellbeing. Resident 8s scher leg was first documented on 06/19/days prior to this incident. Resident's 10/26/2023 to advise for further medica including psychosocial. Resident 8 officinterventions to deter uninvited resident entering her room. i.e. velcro stop sign sensor in doorway, etc. A thorough investigation for this allegate began immediately when LTC managemade aware on 7/17/2023. Law enforce was notified 10/26/2023 and the State Department of Health Report was filed 10/26/2023. Abuse allegations will be adaily for appropriate reporting. Residents 19 and 20 have had separate rooms since 7/23/2022. Resident 20 hwanting to continue to have her husbar Resident 19, visit her in her room; familiagreement as well. On 11/21/2023, So Sevices Director visited with Resident eview psychosocial wellbeing and feel safety in the facility. Resident 20 states feels safe in the facility. She expressed	e, how the the 1-5 with ed 1-5	

knew, she was on the floor.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ОМЕ	STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST VIBORG, SD 57070		
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F 600	*She said that several claims, but nothing was she expressed that should walk by her room the received of the said that should walk by her room to a different part of the accusations. Interview on 10/24/23 practical nurse (LPN) revealed: *She was aware of rescaled that she had been working that the alleged rape of the she confirmed that respectively and the she can she was she found that the she confirmed that respectively and the respectively and the she can she was she was noted. The incident was found that requested that staff in was "being taken care system." The incident was noted. She and the other states of her case was solved that staff in was she and the other states of her case was solved. The incident was noted. The she and the other states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the states of her case was solved that staff in the sta	I staff had known about her as done to address them. She feared the males that om. I at 11:08 a.m. with certified (A) Q about the above alk and make accusations." Into the had since been moved the facility due to the (A) at 11:15 a.m. with licensed (B) at 11:15 a.m. with licensed (B) about the above incident (B) at 11:15 a.m. with licensed (B) about the above incident (B) at 11:15 a.m. with licensed (B) at 11:	F 600	concern related to staff or other resident specifically inquired about feelings of sa during visits with her spouse. Resident 2 she feels safe around her spouse. She i comfortable with private visits and prefehave visits with him in her room. She de the need for visits to be held in public se Resident 20 offered counseling services SSD/designee will meet with resident 20 1 x/week for 4 weeks to evaluate her we Interviewable nursing home residents winterviewed in July and asked if they felt secure and 100% answered yes. On the morning of 10/26, interviewable resident interviewed individually and asked if they safe and secure and 100% answered yes. A directed in-service training was held of 10/26/2023 for all LTC staff of nursing, services, activities, dietary, housekeepinglaundry, maintenance, and therapy on the following: The Abuse Prevention Plan Princluding physical abuse, sexual abuse, psychosocial abuse, neglect, involuntary seclusion, exploitation, misappropriation resident's property, an attempt to commagainst a patient, physical harm or injury profanity, and deprivation of goods or set The responsibility of every employee to suspicion or allegation of abuse to LTC management immediately regardless of substantiated in their view. Staff not ava 10/26/2023 were tracked and additional occurred, or a paper education provided sign off and quiz. A directed in-service was held on 10/26/from Good Samaritan Society Regional Services Director and Accreditation Spe Consultant to educate appropriate manaincluding the administrator, Director of Noirector of Social Services, and Risk Off regarding the abuse prevention policy, to abuse, reporting any allegation of abuse timely reporting to SD DOH. Long Term Care Management will condurandom staff interviews weekly for 4 weekly for 4 weeks and the monthly for 3 months to determine understanding of our abuse policy.Long Care Management will conduct Abuse p quizzes for staff competencies and/or at neglect drills weekly for 4 weeks and the monthly for 3 months.	fety 20 states s rs to cclined dttings. Illbeing. ere safe and es ss were y felt es. cocial eg, ne colicy of a it a crime frices. report a if it is ailable on training with a 2023 Clinical cialist regers, flursing, ficer, ypes of e, and uct 10 eks and Term olicy ouse and

PRINTED: 11/14/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 10/31/2023 435120 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 NORTH WASHINGTON ST PIONEER MEMORIAL NURSING HOME **VIBORG. SD 57070** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)1D (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Findings will be taken to QAPI monthly for F 600 review and revision as warranted. F 600 Continued From page 3 The Administrator will be responsible for the about the facility, and into other resident's rooms. completion of the Plan of Correction. *On 6/27/23, the male resident was found in resident 8's bed. *She explained that resident 8 usually slept in her recliner. *On that night, she woke up and saw a man in her bed; she thought that man was her deceased husband. *She got up from her recliner and fell. *DSS D confirmed that resident 8 did have a scratch and a scar on her foot. -She believed the scratch happened when resident 8 fell. *Since the resident's statements were inconsistent, and due to their internal investigation not finding evidence that a sexual assault had taken place, the management team did not contact the police or file a report with the South Dakota Department of Health (SD DOH). *She confirmed that since the incident, resident 8 was apprehensive of other people walking up and down the hallways. *Resident 8 had not made any allegations of rape until 7/14/23. -Social services had not been informed of the allegations until 7/17/23. -She confirmed that there was at least one nurse

*She confirmed that:

part of the facility on 7/6/23.

who had known about resident 8's allegations and had not reported those allegations to anyone.

-It was her expectation that any allegation such as rape should have been reported right away to

-The alleged perpetrator was moved to a different

the management staff. It was up to the management staff to then report appropriate incidents to the SD DOH and law enforcement.

-Resident 8 had not been evaluated by a physician or mental health practitioner in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 600	(MDS) assessments a *On the 5/6/23 annual a Brief Interview for N of 11, indicating mode *On the 7/29/23 quark had a BIMS score of cognitive impairment. *She had pertinent didisease, Parkinson's Review of a nurse's particle 11:14 p.m. revealed: *"Resident upset this regarding man that lives he stops to rest and Resident states that a sis as she can't sleep in Provided reassurance went [sic] to bed and the hall and has not expressed to rest and the states as safe and the Resident then states before until that other Provided reassurance and that staff are here. That nurse had not recomment of an allege. The alleged rape was when social services an unidentified nurse.	B's Minimum Data Set revealed: If MDS assessment, she had dental Status (BIMS) score erate cognitive impairment. Iterly MDS assessment, she had agnoses of Alzheimer's disease, and depression. If or	F	600			

		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION .	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PIONEER	MEMORIAL NURSING H	OME		'	VIBORG, SD 57070		
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F 600	Interviews with reside electronic medical recontinued signs of age motional distress. Salleged rape was litig system. There was moreport to the SD Dassessed physically dincident. IMMEDIATE JEOPAR Notice of immediate and in writing on 10/2 administrator A and of They were asked for IMMEDIATE JEOPAR On 10/26/23 at 4:09 provided the survey dimmediate jeopardy of plan had been approach 10/26/23 at 4:17 p.m. long-term care advisors. The provider gave the immediate jeopardy of 4:09 p.m.: *"Pioneer Memorial provider gave the immediate jeopardy of 4:09 p.m.: *"Pioneer Memorial provider gave the immediate jeopardy of 4:09 p.m.: *"Pioneer Memorial provider gave the immediate jeopardy of 4:09 p.m.: *"Pioneer Memorial provider gave the immediate jeopardy of 4:09 p.m.: *"Pioneer Memorial provider gave the immediate jeopardy of 10/26/2023 and are and 10/26/2023 and are and secure, responsible to the provider gave the immediate jeopardy of 10/26/2023 and are and 10/26/2023 and are and 10/26/2023 and are and 10/26/2023 at 1:00 spoke with [resident safe and secure, responsible gave gave gave gave gave gave gave gav	ent 8 and a review of her cord (EMR) showed ditation and elevated the continued to believe the ated through the court of police report. There was soon and the continued to believe the ated through the court of police report. There was soon and the cord of th	F	600			

one needing care like here, how likely would you

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		435120	B. WING				10/31/2023
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F 600	with 4 (on a scale of SS [social services] a using the Trauma Sc Director asked [resid speak more to some her experiences and and she said, 'no.' Sc clarified that she is cand resident had no she does currently m regularly and are aw. Counselors have inc. 7/28/2023 and 7/31/2 meet with [resident 8 allow resident to sha evaluate her psychos MD [medical doctor] assessing her 10/26/medical needs. [Resinterventions to deterentering her room. i.e. sensor in doorway, eInterviewed in July are secure and 100% and of 10/26, Interviewab interviewed individual and secure and 100% on 10/26 at 9:30 am training from Good SC Clinical Services Direst Specialist Consultant prevention policy, typallegation of abuse, a DOH. On 10/26/2023 at 2:00 nursing, social services	and the resident answered 1-5 with 5 being the highest). also reassessed resident areen on 10/26/2023. SS ent 8] if she would like to one, like a counselor, about how they are affecting her ocial Services Director currently seeing a counselor recollection of the fact that leet with two counselors are of this incident. luded in their visit notes from 2023. SSD/designee will 1 2 x's/week for 4 weeks to are concerns/feelings and to associal wellbeing. Resident's notified 10/26/2023 and 2023 to advise for further and additional services of the fact that the concerns/feelings and to associal wellbeing. Resident's notified 10/26/2023 and 2023 to advise for further and additional services of the fact that the concerns/feelings and to associal wellbeing. Resident's notified 10/26/2023 and 2023 to advise for further and advise for further and asked if they felt safe and asked if they felt safe and askered yes. On the morning alle residents were ally and asked if they felt safe	F	600			

		D HUMAN SERVICES					APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		435120	B. WING			10/3	31/2023
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F 600	therapy will receive e The Abuse Prevention physical abuse, sexuabuse, neglect, involuexploitation, misapproproperty, an attempt patient, physical harm deprivation of goods responsibility of every suspicion or allegation management immedisubstantiated in their Director provided spefinancial, physical, armaintaining HIPAA [Hand Accountability Aceducational meeting. 10/26/2023 will be tratrainings will occur, oprovided with a sign of Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff interview then monthly for 3 munderstanding of our Long Term Care Manarandom staff i	ducation on the following: In Plan Policy including al abuse, psychosocial untary seclusion, opriation of a resident's to commit a crime against a in or injury, profanity, and or services. The y employee to report a in of abuse to LTC ately regardless of it is view. Social Services ecific examples of sexual, ind verbal abuse while dealth Insurance Portability et] protocols during the Staff not available on acked and additional in a paper education will be off and quiz. Inagement will conduct 10 ws weekly for 4 weeks and onths to determine abuse policy. Inagement will conduct Abuse off competencies and/or cills weekly for 4 weeks and onths. In to QAPI monthly for review anted."	F	600			

PRINTED: 11/14/2023

NAME OF PROMDER OR SUPPLIER PIONEER MEMORIAL NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (REGULATION FOR LSC IDENTIFYING INFORMATION) F 600 Continued From page 8 "That looking back she now knows that the incident should have been reported to both law enforcement and the SD DOH. "That her expectation was that all required incidents should have been reported to the proper authorities. Interview on 10/31/25 at 1:30 p.m. with administrator A revealed that her expectation was that the incident between both residents 8 and 28 should have been reported to both law enforcement and No DOH when they occurred. 5. Review of a nurse's psychotropic drug review note on 10/3/23 revealed resident 8 'continues to talk about rape charge and scrape on her leg." B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (20) had been protected from verbal and physical abuse by her husband, resident (19) while both resided in the facility. Findings include: 1. Observation and interview on 10/24/23 at 2:05 p.m. with resident 20 about her experience in the nursing home revealed: 2. Review of resident 205 EMR revealed:	ALLIVERY OF BELLEVIEW		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
PONEER MEMORIAL NURSING HOME SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG COntinued From page 8 "That looking back she now knows that the incident should have been reported to both law enforcement and the SD DOH. "That her expectation was that all required incidents should have been reported to both law enforcement and between both residents 8 and 28 should have been reported to both law enforcement and between both residents 8 and 28 should have been reported to both law enforcement and SD DOH when they occurred. 5. Review of a nurse's psychotropic drug review note on 10/3/23 revealed resident 8 "continues to talk about rape charge and scrape on her leg." B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (20) had been protected from verbal and physical abuse by her husband, resident (19) while both resided in the facility, Findings include: 1. Observation and interview on 10/24/23 at 2:05 p.m. with resident 20 about her experience in the nursing home revealed: "She had been in her chair since 9:00 a.m. "She said she had had a stroke two years ago and could not move her right side.			435120	B. WING		10/31/2023
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 8 "That looking back she now knows that the incident should have been reported to both law enforcement and the SD DOH. "That her expectation was that all required incidents should have been reported to both law enforcement and the SD DOH. "That her expectation was that all required incidents should have been reported to the proper authorities. Interview on 10/31/25 at 1:30 p.m. with administrator A revealed that her expectation was that the incident between both residents 8 and 28 should have been reported to both law enforcement and SD DOH when they occurred. 5. Review of a nurse's psychotropic drug review note on 10/3/23 revealed resident 8 "continues to talk about rape charge and scrape on her leg." B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (20) had been protected from verbal and physical abuse by her husband, resident (19) while both resided in the facility. Findings include: 1. Observation and interview on 10/24/23 at 2:05 p.m. with resident 20 about her experience in the nursing home revealed: "She had been in her chair since 9:00 a.m. "She said she had had a stroke two years ago and could not move her right side.			OME		315 NORTH WASHINGTON ST	CODE
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*Resident 19 was her husband and she had shared a room with him. *On 9/21/23 resident 19 had struck her on the right arm causing pain to her. *The incident was not reported to staff until 9/28/23 by their daughter.	F 600	*That looking back shincident should have enforcement and the *That her expectation incidents should have authorities. Interview on 10/31/25 administrator A reveat that the incident betwishould have been repenforcement and SD 5. Review of a nurse note on 10/3/23 reveatalk about rape charges. B. Based on observation review, and policy revensure one of one sabeen protected from her husband, resident the facility. Findings include: 1. Observation and in p.m. with resident 20 nursing home reveale *She had been in her she said she had had and could not move to 2. Review of resident *Resident 19 was he shared a room with her *On 9/21/23 resident right arm causing pair *The incident was not the should have a shared a room with the	ne now knows that the been reported to both law SD DOH. In was that all required been reported to the proper of at 1:30 p.m. with alled that her expectation was been both residents 8 and 28 borted to both law DOH when they occurred. It is psychotropic drug review alled resident 8 "continues to be and scrape on her leg." It ion, interview, record view, the provider failed to ampled resident (20) had everbal and physical abuse by the total and a stroke two years ago the right side. It is to be to both law and she had the physical abuse by the total and stroke two years ago the right side. It is to be to both law and she had the physical abuse by the total and stroke two years ago the right side. It is to be to both law and she had the physical abuse by the total and the physical abuse by the total and physical abuse by the provider failed to the physical abuse by t	F	600	

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		435120	B. WING			10/:	31/2023
	ROVIDER OR SUPPLIER	OME	,	31	TREET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH WASHINGTON ST 1BORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	want her husband tak *The provider contact reported the incident 3. Interview on 10/25 resident 20's daughte *She was told by resi hit her and that it had *Resident 19 became him believing that res relationship with anot marriage, which led t 20. *The daughter explai never hit resident 20 *When asked to repe the daughter denied an accident. *She explained that r defended resident 19 Interview on 10/31/23 20 revealed when sh 19 hitting her that she that he only "tapped" Interview on 10/25/23 revealed: *Both residents 19 at together in public spa *If both residents 19 alone, the door shou *If an incident occurr 20, it should have be behavior log.	that she felt safe and did not gen away. Ited law enforcement and to the SD DOH. Iter revealed: Ident 20 that resident 19 had la hurt. Ite angry at resident 20 due to sident 20 had a romantic ther resident prior to their or resident 19 hitting resident 19 had before. Ite and clarify the incident, the incident and said it was resident 20 would have an omatter what. Ite and saked about resident to evas asked about resident to evas asked about resident to ther. Ite and 20 should have spent time aces. Ite and 20 were in a room	F	600			

Facility ID: 0101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		435120	B. WING _			0/31/2023	
	ROVIDER OR SUPPLIER MEMORIAL NURSING F	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST VIBORG, SD 57070			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	10/31/23 at 1:38 p.m resident 19 was seen him not being able to was redirected and w 5. Interview on 10/31 revealed: *The incident was regand 20's daughter on *Resident 19 was mode a private room down corner from resident resident 20 did not with having her husb resident 20 later sate her and that it was an Interview on 10/31/23 administrator A reveat reported to a staff me filed with SD DOH are notified. 6. Review of the prove Prevention Plan political research and that it was in sexual harassment, sassault, or inappropring nonconsensual sexual resident." "E. Neglect is the fair	a 19's behavior logs on revealed that on 10/28/23 a yelling at resident 20 about watch the football game. He was fine after this incident. //23 at 11:27 a.m. with DSS D ported by both resident 19 a 9/28/23. Inved from their joint room to the hall and around the 20's room. Voice any safety concerns and in the facility. In accident. B at 1:28 p.m. with alled after the incident was ember, a report had been and law enforcement was a rider's 10/20/22 "Abuse cy revealed: "as" section: cludes, but is not limited to, sexual coercion, sexual inter touch. Sexual abuse is all contact of any type with a	F 60				
	and services to a res physical harm, pain, distress." *Under the "Respons	ident necessary to avoid mental anguish, or emotional					

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	. 0938-0391
TATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435120	B. WING		 %	10/	31/2023
	ROVIDER OR SUPPLIER	ОМЕ	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST VIBORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	and local law enforce department director winformation and initial -"B. It is the responsil Nursing (DON) of Lor designee or the DON to:""1. Monitor incident who are repeatedly ir incidents to identify a"2. Notify the family or abuse of the reside"3. Report to the DO reporting form or fax ombudsman [ombuds redacted] and local lanumbers redacted] if individual, any allega or abuse within the realleged mistreatment"4. Submit REQUIR EVENT REPORT (on Coordinator per instrict."5. Investigate repomistreatment, neglect results of the investig (5) working days on SREPORT (on-line)." *Under the "Policy" s -"A. PMH&HS [Pione Health Services] will be free from verbal, s abuse, corporal punits seclusion by anyone staff, other residents.	report directly to the DOH ment agency or to his/her who will document the te the investigation." bility of the Director of ing Term Care Services or of the Hospital or designee reports to identify residents higher or involved in trend." of the allegation of neglect tent." OH [email redacted] on-line to [fax number redacted] sman phone number aw enforcement [phone not already reported by an tion of mistreatment, neglect, equired time frame of the neglect, or abuse." EED NURSING FACILITY I line) to DOH Complaint functions of form." red allegations of t, or abuse and file the pation with DOH within five to DAY INVESTIGATIVE ection: er Memorial Hospital and ensure the resident's right to sexual, physical and mental ensure that resident is remainly including but not limited to to consultants or volunteers, es serving the resident, family	F	600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/14/2023

FORM APPROVED

PRINTED: 11/14/2023 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUR COMPLETE					
		435120	B. WING		10/3	31/2023
	ROVIDER OR SUPPLIER MEMORIAL NURSING H	OME	3	TREET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH WASHINGTON ST (IBORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609 SS=J	-"C3. According to Administrative Rules, shall also report to the any other licensed fawithin 48 hours of the NURSING FACILITY on-line Any allegated any patient by any perference of Alleged CFR(s): 483.12(b)(5) §483.12(c) In responsing abuse, negligible mistreatment, including source and misapproare reported immediated hours after the allegates that cause the allegates are administrator of the a	o South Dakota 44:73:01:07, PMH&HS e (DOH) within 24 hours and cility shall report to the DOH e event using REQUIRED EVENT REPORTING form ion of abuse or neglect of erson." Violations (i)(A)(B)(c)(1)(4) se to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, etely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if e the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established	F 609	The Administrator, Director of Nursing (DON) interdisciplinary team in collaboration with the medical director to review, revise, create, as necessary, policy and procedure for a thorou investigation, documentation, and reporting pnecessary authority per regulation, regardles resident family preference. A directed in-service training was held on 10/6 rall LTC staff of nursing, social services, addietary, housekeeping, laundry, maintenance therapy on the following: The Abuse Preventi Policy including physical abuse, sexual abus psychosocial abuse, neglect, involuntary see exploitation, misappropriation of a resident's an attempt to commit a crime against a patier physical harm or injury, profanity, and deprivagoods or services. The responsibility of everemployee to report any suspicion or allegation abuse to LTC management immediately regaif it is substantiated in their view. Staff not avolved to the substantiated in their view. Staff not avolved to a proper and a cocurred, or a paper education provided with and quiz. A directed in-service was held on 10/26/2023 Good Samaritan Society Regional Clinical Securation of a properiate managers, including the administrator, Director of Nursing, Director and Accreditation Specialist Consult educate appropriate managers, including the administrator, Director of Nursing, Director of Services, and Risk Officer, regarding the abust prevention policy, types of abuse, reporting a allegation of abuse, and timely reporting to Services, and Risk Officer, regarding the abust prevention policy, types of abuse, reporting a legation of abuse, and timely reporting to Services, and Risk Officer, regarding the abust prevention policy, types of abuse, reporting a legation of abuse, and timely reporting to Services, and Risk Officer, regarding the abust prevention policy, types of abuse, reporting a legation of abuse, and timely reporting to Services, and timely reporting to Services, and timely reporting to Services, and timely reporting to Services.	gh event process to sof (26/2023 ctivities, and ion Plan se, lusion, property, nt, ation of y no fardless of vailable on ing a sign off services and to (5 Social see in y D DOH. do the on yed daily will be skly for 4 2. view and	11/22/2023

Facility ID: 0101

Event ID: UOGP11

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/14/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
	•	435120	B. WING_			10/31/2023
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CO 315 NORTH WASHINGTON ST VIBORG, SD 57070)DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	appropriate correct This REQUIREME by: Based on observation and policy review, allegation of sexual toward resident (2) and reported to the Health (SD DOH). Findings include: 1. Observation and a.m. with resident nursing home reversion and the perpetrator she alleged that and the perpetrator being leverage." *She was able to reperpetrator's name resident at the nuresident at the nuresi	tive action must be taken. NT is not met as evidenced ation, interview, record review, the provider failed to ensure an all assault made by resident (8) B) was thoroughly investigated be South Dakota Department of d interview on 10/24/23 at 10:25 8 about her experience in the bealed: behe was raped at that facility or "did not complete." ration on her left shin and foot acquired from the alleged on top of her trying to "get remember the alleged be and said he was another sing home. Is now in a different part of the I she had informed someone I she had informed someone I she woke up and saw the I she woke up and saw the I in her bed. The next thing she I the floor. I was done to address them. I hat she feared the males that	F6	09		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		435120	B. WNG			10/	31/2023
	ROVIDER OR SUPPLIER	ОМЕ	•	314	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH WASHINGTON ST BORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 609	incident revealed: *The alleged perpetra about the facility, and *On 6/27/23, the male resident 8's bed. *She explained that re recliner. *On that night, she we her bed; she thought husband. *She got up from her *DSS D confirmed the scratch on her footShe believed the scr resident 8 fell. *Since the resident's inconsistent, and due not finding evidence of taken place, the man- contact the police or to DOHThey "did not feel it of report [the alleged rap *She confirmed that s was apprehensive of down the hallways. *Resident 8 had not r until a couple of weel -She mentioned there 7/14/23 written by a r alleged rapeSocial services had allegations until 7/17/ -She confirmed that t who had known about had not reported thos -It was her expectation as rape should have	ator was known to wander into other resident's rooms. The resident was found in the sident 8 usually slept in her toke up and saw a man in that man was her deceased recliner and fell. The statements were to an internal investigation that a sexual assault had agement team did not file a report with the SD rescalated to that level to pel." Since the incident, resident 8 other people walking up and made any allegations of rape as after 6/27/23. The was a progress note on the statement of the mot been informed of the	F	609			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE S COMPL	
		435120	B. WING			10/3	31/2023
NAME OF P	ROVIDER OR SUPPLIER			l l	TREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER	MEMORIAL NURSING H	OME		ı	15 NORTH WASHINGTON ST IBORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	moved to a different process of remedical record (EMR *There was a nurse's note on 10/3/23 whice "continues to talk about on her leg." *The 5/6/23 annual Massessment, her Brief (BIMS) score was 11 cognitive impairment *The 7/29/23 quarter BIMS score was 12, cognitive impairment *She had diagnoses Parkinson's disease, Email communication Complaint department confirmed there was regarding the alleged 3. IMMEDIATE JEOF HARM Interviews with reside EMR showed continuelevated emotional displayed to the alleged recourt system. There was no report to the assessed physically incident. IMMEDIATE JEOPAI Notice of immediate and in writing on 10/3 administrator A and conditions are reconstructed and in writing on 10/3 administrator A and conditions are reconstructed.	esident 8's electronic by revealed: spychotropic drug review h indicated resident 8 but rape charge and scrape Minimum Data Set (MDS) of Interview for Mental Status , which indicated moderate . If MDS assessment, her which indicated moderate . of Alzheimer's disease, and depression. In with the SD DOH Int on 10/24/23 at 10:54 a.m. In or report submitted di rape. PARDY PSYCHOSOCIAL eent 8 and a review of her used signs of agitation and distress. She continued to ape was litigated through the was no police report. There SD DOH. She had not been or mentally regarding this RDY NOTICE jeopardy was given verbally	F	609			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLETI				
		435120	B. WING			10/	31/2023
	ROVIDER OR SUPPLIER	OME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 115 NORTH WASHINGTON ST /IBORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	e 16 RDY REMOVAL PLAN	F	3 0 9			
	immediate jeopardy roplan had been approv	o.m., administrator A eam with a final written emoval plan. The removal yed by the long-term care OH on 10/26/23 at 2:26 p.m.					
	immediate jeopardy re 2:15 p.m.: "Pioneer Memorial pe Viborg City Chief Poli 10/26/2023 and are a Department of Health am on 10/26/2023. On 10/26/2023 all into were audited for accurrent 6/1/2023 [to] cur On 10/26 at 9:30 am Management includin of Nursing, Director o Officer received traini Society Regional Clin Accreditation Speciali abuse prevention poli any allegation of abus SD DOH. On 10/26/2023 at 2:0	waiting a reply. The State Report was filed at 11:40 ernal investigative events fracy in reporting to SD DOH rent. LTC [Long-Term Care] g the administrator, Director f Social Services, and Risk ng from Good Samaritan ical Services Director and ist Consultant regarding the cy, types of abuse, reporting se, and timely reporting to 0 [p.m.] all available LTC					
	housekeeping, laundr therapy received edu- Abuse Prevention Pla abuse, sexual abuse, neglect, involuntary s misappropriation of a attempt to commit a c physical harm or injur	cation on the following: The an Policy including physical					

		ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		E SURVEY PLETED
		435120	B. WING			10	/31/2023
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
				315	NORTH WASHINGTON ST		
PIONEER MEMORIAL NURSING HOME				VIB	ORG, SD 57070		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 609	employee to report a abuse to LTC manag regardless of it is sub Staff not available on and additional trainin education will be proquiz. Abuse allegatio appropriate reporting All incident reports w administrator weekly x's 2, then monthly x'QAPI [Quality Assura Improvement] month warranted." The immediate jeopa 10/30/23 at 11:30 a.r provider had implem After the removal of scope and severity of the provider had implement the "Definitio". C. Sexual Abuse in sexual harassment, assault, or inappropring nonconsensual sexual resident." "E. Neglect is the facemployees or service and services to a resphysical harm, pain, distress." "Under the "Responsental is the responsental is the responsental in the responsental is the responsental in th	suspicion or allegation of ement immediately ostantiated in their view. 10/26/2023 will be tracked gs will occur, or a paper vided with a sign off and ns will be reviewed daily for ill be audited by the for 4 weeks, then biweekly is 2. Findings will be taken to ance and Performance ly for review and revision as ardy was removed on an after verification that the ented their removal plan. The immediate jeopardy, the f the citation level was "G." vider's 10/20/22 "Abuse icy revealed: ns" section: Includes, but is not limited to, sexual coercion, sexual inter touch. Sexual abuse is all contact of any type with a sillure of the facility, its exproviders to provide goods sident necessary to avoid mental anguish, or emotional	F	609			

PRINTED: 11/14/2023

serious bodily harm, report directly to the DOH and local law enforcement agency or to his/her

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	` '	E SURVEY IPLETED
		435120	B. WING			10	0/31/2023
	ROVIDER OR SUPPLIER	OME	,	315	REET ADDRESS, CITY, STATE, ZIP CODE NORTH WASHINGTON ST RORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	information and initia -"B. It is the responsi Nursing (DON) of Lo designee or the DON to:""1. Monitor incident who are repeatedly it incidents to identify a"2. Notify the family or abuse of the resid"3. Report to the DO reporting form or fax ombudsman [ombuds redacted] and local is numbers redacted] if individual, any allega or abuse within the re alleged mistreatment"4. Submit REQUIS EVENT REPORT (or Coordinator per instri"5. Investigate repo mistreatment, negled results of the investig (5) working days on is REPORT (on-line)." *Under the "Policy" s -"A. PMH&HS [Pione Health Services] will be free from verbal, s abuse, corporal punis seclusion by anyone, staff, other residents, staff of other agencie members, friends or -"C3. According t Administrative Rules."	who will document the te the investigation." bility of the Director of ng Term Care Services or I of the Hospital or designee reports to identify residents njured or involved in I trend." of the allegation of neglect ent." OH [email redacted] on-line to [fax number redacted] sman phone number aw enforcement [phone not already reported by an tion of mistreatment, neglect, equired time frame of the neglect, or abuse." RED NURSING FACILITY I line) to DOH Complaint fuctions of form." red allegations of t, or abuse and file the lation with DOH within five DAY INVESTIGATIVE ection: er Memorial Hospital and ensure the resident's right to sexual, physical and mental shment and involuntary including but not limited to consultants or volunteers, s serving the resident, family other individuals."	F	609			

		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 11/14/2023 1 APPROVED): 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435120	B. WING_		10/	31/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PIONEER MEMORIAL NURSING HOME				VIBORG, SD 57070		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	within 48 hours of the NURSING FACILITY	cility shall report to the DOH e event using REQUIRED EVENT REPORTING form ion of abuse or neglect of	F6	609		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/14/2023 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_			0.0930-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		435120	B. WING			10/	31/2023
	ROVIDER OR SUPPLIER	HOME		315	REET ADDRESS, CITY, STATE, ZIP CODE S NORTH WASHINGTON ST BORG, SD 57070		
	CLIMMADY C	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	COMPLETION DATE
E 000	Initial Comments		E	000			
	CFR Part 482, Subp Emergency Prepared Term Care facilities of through 10/25/23, ar	vey for compliance with 42 art B, Subsection 483.73, dness, requirements for Long was conducted from 10/24/23 and from 10/30/23 through emorial Nursing Home was					
						3	
,							
	Ġ.						
					TITI I		(X6) DATE
1 ind	new Hauger	R/SUPPLIER REPRESENTATIVE'S SIGNATU			TITLE Administrator		/16/2023
Any deficienc	y setement ending with an ords provide sufficient profet date of survey whether or or the date these documents				excused from correcting providing it is determined mes, the findings stated above are disclosable 90 ove findings and plans of correction are disclosable approved plan of correction is requisite to continu		

FORM CMS-2567(02-99) Previous Versions Obsolete SD DOH-OLC

program participation.

Event ID: UOGP11

NOV 2 2 2023

Facility ID: 0101

If continuation sheet Page 1 of 1

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY MPLETED
		435120	B. WING _		1	0/24/2023
	ROVIDER OR SUPPLIER MEMORIAL NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST VIBORG, SD 57070		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	3	К0	000		
	Life Safety Code (LS occupancy) was cond Memorial Nursing Ho	rey for compliance with the C) (2012 existing health care ducted on 10/24/23. Pioneer ome was found in compliance (a) requirements for Long				
ADOBATORY	DIRECTOR'S OR PROVIDER	NSUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
	sey Hauger	 		Administrato	or	11/16/202

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event ID: U0GP21

Facility ID: 0101

If continuation sheet Page 1 of 1

PRINTED: 11/14/2023 FORM APPROVED South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ 10/31/2023 B. WNG 10698 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 315 N WASHINGTON ST PIONEER MEMORIAL NURSING HOME VIBORG, SD 57070 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/24/23 through 10/25/23, and from 10/30/23 through 10/31/23. Pioneer Memorial Nursing Home was found in compliance. S 000 S 000 Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/24/23 through 10/25/23, and from 10/30/23 through 10/31/23. Pioneer Memorial Nursing Home was found in compliance.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REGRESEITATIVE SIGNATURE Administrator BK9G11 NOV 2 2 2023

SD DCH-OLC

TITLE

(X6) DATE

11/16/2023

If continuation sheet 1 of 1